GARIMA LAL, MD, FAAP
Board Certified, American Board of Ophthalmology
General and Pediatric Ophthalmology and Strabismus

WELCOME TO OUR OFFICE

Patient's Full Name *(NOMBRE)* **:**_____ **Today's date***(FECHA)*:_____
Mailing Address *(DIRECCIÓN)*:

Street:_____ **Apt. #** _____

_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone: (_____) _____ **Work Phone**:(_____)_____
(TELÉFONO) *(TELEFONO DEL EMPLEADOR)*
Cell Phone: (_____) _____
(TELÉFONO DE CELLULAR)
(Check one): **Sex:** Male *(HOMBRE)* Female *(DAMAS)*
Age*(EDAD)* **:** _____ **Date of Birth:**_____ **SS:**
(FECHA DE NACIMIENTO) **(***NO. SEGURO SOCIAL)*

Occupation/School grade:_____ **Name of employer/school:**_____
(OCUPACIÓN) *(NOMBRE DEL EMPLEADOR)*

Pediatrician/Family Physician:
(DOCTOR GENERAL)
Name: _____
Office Address:
_____
_____
_____
Office phone: (_____) _____
Office fax: (_____)_____

Other physicians to receive a report:
Name: _____
Specialty: _____
Address: _____
_____
Office phone: (_____) _____
Office fax: (_____)_____

Were you referred to us by your pediatrician or primary care doctor? (check one) ☐ Yes ☐ No
If "No", who referred you, or how did you hear of us? _____

WE HAVE TRANSITIONED TO ELECTRONIC MEDICAL RECORDKEEPING AND WILL BE COMMUNICATING APPOINTMENT REMINDERS, RECALLS, and BILLING CONCERNS ELECTRONICALLY.

EMAIL ADDRESS:_____ **CELLULAR**: _____

Family Status: Patient is ☐ living with parent(s) or ☐ living with relative, guardian, or foster parent
Parents/Patient are (check one) ☐ married ☐ separated ☐ divorced ☐ single

The primary policy holder for this patient is the: (Circle on ☐ **Mother** ☐ **Father** ☐ **Spouse**

Full Name of Spouse/ Father*(PADRE)* **(or guardian)**:_____ **Date of Birth:**____/____/____
Occupation:_____ **Daytime Phone**:(_____)_____ **SS#**:_____

Full Name of Spouse/Mother*(MADRE)* **(or guardian):**_____ **Date of Birth**:____/____/_____
Occupation:_____ **Daytime Phone**:(_____)_____ **SS#**:_____

Emergency name/phone number where parents/guardians can be reached *(EN CASO DE EMERGENCIA)*:
Name: _____ **Phone**:_____
Relationship to patient:

Names of other relatives who are patients of the doctor:_____

I authorize Pediatric Eye Associates, Inc. to medically exam and treat the above named patient.

Guardian signature:_____ **Relationship**:_____

Garima Lal, MD **Pediatric Eye Associates, Inc/Family Ophthalmology Center**

Consent for Disclosure of Medical Information (Permiso para divulgar su condición médica)

I, _____, hereby allow and give consent for the following family members, friends, or health care surrogates to accompany me in the exam room during my visit or discuss my health information with the physician:

Yo _____ autorizo a los siguientes familiars, amistades o personas a cargo de mi bienestar, a presenciar o discutir mi condición de salud durante mi visita o la visita de mi hijo/a con el médico:

1. _____

2. _____

3. _____

4. _____

May we leave a message on your answering machine, cell phone, or with the person that answers the phone?
(Nos permite dejar un mensaje en su grabadora, cellular, o con la persona que conteste el teléfono?)
(check one): ☐ YES (SI) OR ☐ NO (NON)

May we comunícate with you via email, and/or text messaging, regarding appointments, billing inquires and other administrative questions?
(Nos permite enviar un mensaje electrónico y / o celular sobre su appointment, sus billes u alguna otra pregunta sobre su infomacion medica?)

(check one): ☐ YES (SI) OR ☐ NO (NON)

EMAIL: _____

CELLULAR: _____ CELL PHONE COMPANY:_____

Acknowledgement of Notice of Privacy Practice
Notificacion de Practicas de Privacidad

Patient's name (nombre del Paciente) _____
I hereby acknowledge that I have received the Notice of Privacy Practices statement of Pediatric Eye Associates, Inc., and I may revoke any authorizations at any time by providing written notification of my request.
Hago constar haber recibido una copia de las prácticas de privacidad de Pediatric Eye Associates, Inc. y puedo revocar cualquier autorización en cualquier momento mediante notificación por escrito de mi solicitud.

Signature: **Relationship to Patient:**
(firma del paciente o guardian):

Date (fecha):

GARIMA LAL, MD, FAAP
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WELCOME TO OUR OFFICE

INSURANCE INFORMATION

Your claim can not be paid without the following information

Primary Insurance Company:_____
Policy or ID #:_____
Name of Policy Holder:_____ **Sex:** ___
DOB: _____

Secondary Insurance Company:_____
Policy or ID #:_____
Name of Policy Holder:_____ **Sex:** ___
DOB: _____

VISION PLAN company: _____

ALL PATIENTS AND GUARANTORS: Please read the following paragraphs and sign below:

Consent for examination and treatment
I consent to evaluation and treatment by or under the direction of the physicians of Pediatric Eye Associates, Inc, including his/her associates, fellows and assistants. I understand it is necessary for my pupils to be dilated (enlarged) in order for my retina to be examined. Mydriatic (dilating) drops frequently blur vision and make bright light bothersome. It is not possible to predict how my vision will be affected and for how long. I should not drive a vehicle or operate machinery following my appointment. Adverse reaction, such as acute angle closure glaucoma, may be triggered from dilation. This is extremely rare and treatable with immediate medical attention. I consent to pupil dilation at each visit and understand the visual side effects and risks described above. I understand and agree I should make arrangements not to drive myself following my appointments.

Medicare and Primary Insurance
I request that payment of authorized benefits be made on my behalf to Garima Lal, MD and/or Pediatric Eye Associates, Inc for services furnished to me by the healthcare providers of Pediatric Eye Associates, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and/or any other healthcare insurance plans and their agents responsible for the reimbursement of my healthcare claims any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay my healthcare claims. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or entity Pediatric Eye Associates, Inc. accepts the charge reimbursement determination of the Medicare Carrier and/or my insurance carrier(s) as full reimbursement as provided in their participating provider agreement. I am responsible for copayments, coinsurance, deductible, out-of-pocket expenses and non-covered services as determined by my healthcare plan(s). My signature further verifies that I will notify Pediatric Eye Associates, Inc of any changes to my health insurance coverage status, including benefit and plan changes and if I join an HMO or other plan in which my Medicare or other healthcare benefits have been relinquished. I understand it is my responsibility to update Pediatric Eye Associates, Inc of any changes in my healthcare coverage.

Medigap and Secondary Insurance
I understand that if a Medigap policy or secondary healthcare insurance is indicated, my signature authorizes release of the information to the insurer or entity. I request that payment of authorized secondary insurance benefits be made on my behalf to Garima Lal, MD, and/or Pediatric Eye Associates, Inc. The same shall apply to tertiary and quaternary healthcare benefit polices. This assignment of benefits shall remain in effect unless revoked by me in writing. A copy of this assignment and my signature shall remain on file and is considered as valid as the original.

Healthcare Plan Requirements
Some healthcare plans require the insured to seek medical services from certain healthcare providers or facilities or to obtain a referral, authorization, precertification and/or approval in order to reimburse medical fees and costs. I understand and agree that I have personally reviewed my healthcare plan and understand the coverage restrictions applied to the reimbursement of my medical expenses as determined by my healthcare plan. If I fail to comply with the requirements of my healthcare plan I understand and agree that I am responsible for full payment of all medical services rendered.

Preferred Participating Providers
Pediatric Eye Associates, Inc. participates as in-network providers with most insurance plans. I understand that it is my responsibility to verify participation. If Pediatric Eye Associates, Inc. does not participate with my healthplan, I understand and agree that I am responsible for all fees associated with my care. Payment for services are due when services are rendered and may be made by cash, check, debit card, MasterCard, Visa, Discover and American Express.

OTHER FEES:
$35.00 returned check/nonsufficient funds/chargeback fee
$35.00 NO show fee/non-cancellation fee
$35.00 unused authorizations/expired authorizations due to cancelled appointments (must reschedule within authorization grace period)
$25.00 form completion fee
$5.00 monthly charge for balances over 60 days old
$50.00 charge to send account to collections (in addition to applicable collections fees: 35% of total balance)

Non-covered Services and Advanced Beneficiary Notice

I understand that my healthcare insurance plan may not cover all services even though my physician determines the service(s) to be medically necessary. Examples of non-covered services include, but are not limited to, services not specified as being covered by my healthcare plan, treatment or tests not authorized by my healthcare plan or services that are specifically excluded or limited by my healthcare plan. I understand and agree that a Advanced Beneficiary Notice (ABN) will be obtain any time it is expected that my healthcare plan may not cover a service. I understand and agree that if a service, test, treatment or drug is not covered by my healthcare plan I am personally responsible for the fees associated with any and all non-covered services, unreimbursed, under reimbursed and/or denied services. FOR EXAMPLE, A "*REFRACTION*" IS REQUIRED TO PRESCRIBE GLASSES. IN CHILDREN, THIS SERVICE IS A MEDICALLY NECESSARY PART OF A COMPLETE EYE EXAM. IT IS MOST OFTEN NOT CONSIDERED PART OF MEDICAL CARE AND FALLS UNDER VISION OR ROUTINE EYE COVERAGE, AND MAY BE REFUSED BY YOUR MEDICAL INSURANCE POLICY. UNLESS VERIFIED BY THE INSURANCE COMPANY PRIOR TO YOUR OFFICE VISIT, THE REFRACTION FEE OF $60.00 IS PAYABLE AT THE TIME SERVICES ARE RENDERED. IN CHILDREN, IT IS USUALLY THE REASON FOR THE OFFICE REFERRAL.

Financial Agreement

I understand that insurance is a means of reimbursement and not a substitution for payment. Pediatric Eye Associates, Inc. will file my healthcare claims on my behalf for medical services rendered. I agree to pay all copayments, coinsurance, deductibles, out-of-pocket expenses and non-covered services as determined by my healthcare insurance plan at the time of service. I understand and agree that I am ultimately responsible for payment of all fees for services rendered regardless of my insurance status. I understand and agree to promptly pay any account balances upon the receipt of a statement from Pediatric Eye Associates, Inc. or upon arrival at the office prior to services. Furthermore, I understand and agree that my account may be accessed additional
fees, including interest charges and late fees for outstanding balances, returned payments, the duplication of medical records, special forms or reports and appointment cancellation and no show fees. If it becomes necessary to send my account for collection, I agree to pay collections expenses and fees of 35% of the outstanding balance (as calculated on the due date) which will be added to the outstanding balance. IF the account is referred to an outside attorney for collections, I agree to pay all attorney's fees as established by the court in addition to my outstanding account balance and administrative account fees. **There will be a $35.00 administrative fee for nonsufficient funds, returned checks, or merchant chargebacks.** I understand that it may become necessary to terminate the patient-physician relationship if I fail to meet my financial responsibilities or my financial arrangements become unsatisfactory.

Release of Information

Pediatric Eye Associates, Inc. may disclose all or part of my medical record, including financial information, alcohol or drug abuse, psychiatric illness, communicable disease and/or HIV status to any person or entity which is liable or under contract for reimbursement of medical services rendered and any healthcare providers or entities participating in my medical care. Pediatric Eye Associates, Inc. may also disclose on an anonymous basis any information concerning my care which is necessary or appropriate for the advancement of medical science, medical education, medical research, collection of statistical data or pursuant to local, state or federal law, statute or regulation.

Additional Information

As a courtesy I agree to silence my cellular telephone and other electronic devices upon arrival for my appointments. If I must make or receive a telephone call I will step outside the office. I understand Pediatric Eye Associates, Inc. maintains a smoke free environment and will refrain from the use of all tobacco products while at my appointments. Weapons of any kind are strictly prohibited. My appointment time has been reserved for me and I will notify the office 24 hours in advance if I am unable to keep my appointment. I understand and agree my failure to kept scheduled appointments without properly notifying the office will result in a $35.00 fee to my account and restrictions to future appointment bookings. Authorizations are typically active for 30 days, and if I miss an appointment, I agree to reschedule the appointment within the active time frame. Authorizations that remain un-utilized or become expired, and require our office to make new requests due to cancelled appointments or no show visits, will incur a $35.00 administrative fee. I agree to pay this fee in order to request additional authorizations on my behalf if I am unable to utilize the authorization within the 30 day grace period. **L**ate arrivals will be seen as permitted or rescheduled as needed. I understand that due to the nature of the specialty, emergencies may delay scheduled appointments and occasionally make it necessary to reschedule appointments in order to accommodate emergency surgical care. The physicians and staff understand my time is valuable and will work diligently to minimize the length of my visit and ask for my patience and understanding in advance if delays occur. A copy of this consent, assignment, authorization and agreement may be used in place of the original. I have the right to obtain a paper copy of this notice, upon request, even if I have agreed to accept this notice alternatively i.e. electronically.

PATIENT OR GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____

DATE: _____

Family Ophthalmology Center
Pediatric Eye Associates, Inc.

Patient's Medical History with Review of Systems

PATIENT NAME:_____ TODAY'S DATE:____/____/____

If pediatric patient, name of person completing form:_____ Relationship to patient:_____

HISTORY OF EYE PROBLEMS:

1. What problem(s) are you (your child) having with your eyes?_____

_____

2. Have you (your child) ever had any eye problems, patching treatment or surgery? Please be specific with approximate dates and the doctor who treated you. _____

_____

_____

3. When was your (your child's) last eye exam?_____ Who was the doctor or where?_____
4. Do you (your child) wear glasses? Yes◯ No◯ If yes, how long?_____
5. Do you (your child) wear contact lenses? Yes◯ No◉ If yes,what brand?_____

RECENT EYE SYMPTOMS:

YES	NO		IF YES, WHICH EYE?
◯	◯	Blurred vision	
◯	◯	Double vision	
◯	◯	Glare/light sensitivity	
◯	◯	Burning	
◯	◯	Itching	

YES	NO		IF YES, WHICH EYE?
◯	◯	Pain or soreness	
◯	◯	Excess tearing	
◯	◯	Mucous discharge	
◯	◯	Redness	
◯	◯	Crossed or wandering eye	

***FAMILY* HISTORY:** Do the patient's **relatives** have any of the following?

YES	NO		IF YES, WHO?
◯	◯	Blindness	
◯	◯	Retinal detachment	
◯	◯	Genetic eye disease (runs in the family)	

YES	NO		IF YES, WHO?
◯	◯	Amblyopia (bad vision in one eye)	
◯	◯	History of patching treatment	
◯	◯	Strabismus ("crossed or wandering eye")	

At what age did your child's birth parents begin wearing glasses? Mother_____ Father_____

SOCIAL HISTORY: Do you (your child) smoke? Yes◯ No◯ Do you (your child) drink alcohol? Yes◯ No◯

MEDICAL HISTORY AND REVIEW OF SYSTEMS:

YES	NO		IF YES, EXPLAIN BELOW
◯	◯	Frequent headaches	
◯	◯	Asthma	
◯	◯	Frequent ear infections	
◯	◯	Other ear, nose or throat problems	
◯	◯	Attention Deficit Disorder	
◯	◯	Reading problems/learning disability	
◯	◯	HIV or AIDS	
◯	◯	Fever or weight loss	
◯	◯	Heart problems	
◯	◯	Lung disease	

YES	NO		IF YES, EXPLAIN BELOW
◯	◯	Stomach or intestinal disease	
◯	◯	Kidney or urinary disease	
◯	◯	Skin disease	
◯	◯	Neurologic(brain) problems	
◯	◯	Mental illness	
◯	◯	Cancer	
◯	◯	Genetic diseases in family	
◯	◯	Blood disorder (anemia, etc.)	
◯	◯	Autoimmune disease	

Has the child received the recommended vaccines: Yes◯ No◯ date: _____ Adult influenza vaccine: Yes◯ No◯ Date: _____

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1. **LIST** any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems) **within the last five years:**

_____

_____

_____

2. **LIST** all medications including eye drops:_____

_____

3. **LIST** allergies to medicines or circle none: NONE◯ _____

4. **Birth history for patients 10 years old or younger:** Birth weight:_____lbs_____oz
   Length of pregnancy: ◯Full term ◯ Premature- length of pregnancy if premature_____weeks
   LIST any problems with pregnancy:_____